1 BEFORE THE PERSONNEL APPEALS BOARD 2 STATE OF WASHINGTON 3 4 Case No. DEMO-98-0023 5 CAMERON WHEELOCK, FINDINGS OF FACT, CONCLUSIONS OF 6 Appellant, LAW AND ORDER OF THE BOARD 7 v. 8 DEPARTMENT OF SOCIAL AND HEALTH SERVICES, 9 Respondent. 10 11 I. INTRODUCTION 12 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. 1.1 13 HUBBARD, Chair, and GERALD L. MORGEN, Vice Chair. 14 The hearing was held at the Administrative Building at Western State Hospital, Steilacoom, Washington, on November 5, 1999. 15 NATHAN S. FORD, JR., Member, did not participate in the hearing or in the decision in this matter. 16 17 1.2 Appearances. Appellant Cameron Wheelock was present and was represented by Anita L. 18 Hunter, Attorney at Law, of Parr & Younglove, P.L.L.C. Respondent Department of Social and Health 19 Services was represented by El Shon Richmond, Assistant Attorney General. 20 Nature of Appeal. This is an appeal from a disciplinary sanction of demotion for neglect of 22 1.3 duty, gross misconduct and willful violation of published employing agency rules and regulations. 23 Respondent alleges that contrary to policy, Appellant took a verbal order to administer medication, 24 dispensed the wrong medication, and failed to document it on the patient's medical chart. 25 26

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1.4 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v. School

for the Deaf, PAB No. D89-004 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994); Aquino v. University of Washington, PAB No. D93-163 (1995).

II. FINDINGS OF FACT

Appellant Cameron Wheelock is a Mental Health Technician 1 and permanent employee for

Citations Discussed. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084

2.1

1998.

Respondent Department of Social and Health Services at Western State Hospital. Appellant and

Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles

356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on December 7,

2.2 At the outset of hearing, the parties entered into a stipulated protective order which, in part,

protects the identity of the patient's last names and requires that all exhibits and references in the

transcript of this matter which identify the patient's last name be stricken and not used or referred to

outside of the PAB hearing.

2.3 By letter dated November 14, 1998, Jerry L. Dennis, MD, Chief Executive Officer at Western

State Hospital, informed Appellant of his demotion from his position as a Mental Health Licensed

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Practical Nurse 2 to a position as a Mental Health Technician 1 effective December 2, 1998. Dr. Dennis

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charged Appellant with neglect of duty, gross misconduct and willful violation of published employing

agency or Department of Personnel rules and regulations for administering the wrong medication to a

patient, for failing to chart the medication he administered on the patient's record and for taking a verbal

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order to dispense a medication.

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1	2.4 Appellant began his employment at Western State Hospital (WSH) on March 14, 1988.
2	Appellant received a reduction in salary for failing to properly handle and document an un-prescribed
3	medication he found in patient's drawer in October 1997 (See PAB Case No. RED-98-0010, decision
4	issued October 21, 1999).
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6	2.5 At the time of this incident, Appellant was a medication nurse and was responsible for
7	appropriately administering and documenting medication given to patients on Ward E-7. As a nurse
8	Appellant was responsible for providing patient care. It is undisputed that on June 14, 1998, at
9	approximately 11:30 a.m., Appellant administered 240 ml of Milk of Magnesia to a patient after
10	receiving a verbal order from Dr. Godofredo Mateo.
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12	2.6 WSH's Pharmaceutical Services/Drug Use Control Manual states that "verbal orders are
13	unacceptable except in an emergency situation according to emergency protocol." Additionally,
14	according to hospital protocol, a registered nurse is the only nursing staff authorized to take a verbal
15	order if one is given during an emergency. Appellant was aware of this policy and protocol and admits
16	that he did not wait for Dr. Mateo to write an order documenting the verbal order prior to administering
17	the medication to the patient.
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19	2.7 After he administered the Milk of Magnesia to the patient, Appellant confirmed with Dr. Mateo
20	that the medication had been dispensed. Dr. Mateo informed Appellant that he had ordered that the
21	patient be given Magnesium Citrate, not Milk of Magnesia. As a consequence, Appellant had
22	administered eight times the normal dosage of Milk of Magnesia. Dr. Mateo's written physician's order
23	indicated that the order was for 240 ml Magnesium Citrate, a standard dosage for this medication.
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25	2.8 In accordance with policy Appellant then completed a Medication Incident Report in which he

indicated, "I misheard verbal order given by O.D. [officer of the day]. Apparently O.D. said give 240

1	ml of Magnesium Citrate. I gave equivalent of 240 ml of Magnesium Hydroxide [Milk of Magnesia]
2	." However, Appellant failed to document the medication and dose administered to the patient on the
3	patient's progress notes and Medical Administration Record (MAR).
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5	2.9 A MAR is used to memorialize the administration of all medications given to hospital patients
6	WSH's policy and procedure's manual (Section 6.0), requires that all regularly scheduled medications
7	as well as one-time medications be documented on the MAR form. Appellant was aware of this policy
8	and practice.
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10	2.10 Western State Hospital has adopted Policy 3.4.4 which states that all patients "have the right to
11	be treated in an environment free of neglect, abuse, and of abusive practices" The policy defines
12	patient abuse as "any physical contact, as well as acts of negligence, that involve the patient's body in a
13	non-therapeutic way and that are harmful or jeopardize the safety and welfare of the patient."
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15	2.11 Dr. Jerry Dennis was the Appellant's appointing authority when he imposed Appellant's
16	previous suspension. Prior to determining whether misconduct occurred and what level of discipline to
17	impose, Dr. Dennis reviewed Appellant's personnel record, including his evaluations and prior
18	discipline as well as the investigative report. After reviewing this information, Dr. Dennis concluded
19	that the incident was serious and that Appellant's failure to confirm the verbal order with the written
20	order could have resulted in serious ramifications for the patient.
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22	2.12 Dr. Dennis was concerned that Appellant's failure to document the administration of the
23	medication also posed a risk to the patient because the patient chart and MAR form are methods used to
,	ansure that oncoming staff are informed of all medical issues concerning nationts. In fashioning the

level of discipline, Dr. Jerry Dennis looked at the impact of Appellant's misconduct on the patient, at

Appellant's awareness of hospital policy, and his length of employment with the hospital. Dr. Dennis

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ultimately concluded that a severe punishment was warranted and decided to demote Appellant to a position where he was no longer responsible for administering medication to patients.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant's action of giving a patient eight times the standard dose of the wrong medication was reckless and irresponsible. Respondent argues that Appellant's negligence constitutes patient abuse and would not have occurred if Appellant had waited until the physician completed a written order. Respondent argues that the policy requiring orders for medication to be put in writing was put in place to prevent such errors. Respondent also alleges that Appellant neglected his duty and violated policy when he failed to chart the administration of the medication on the patient's progress notes and MAR. Respondent argues demotion to a position where Appellant has no medication responsibilities is the appropriate sanction and asks the Board to affirm the demotion.

3.2 Appellant argues that he took a verbal order with the understanding that the physician would confirm the order in writing. Appellant asserts that it was not uncommon for nursing staff to administer medication based on a verbal order and that it was not the practice on the ward to chart medication administered if a medication incident report had been completed. Appellant asserts that Dr. Mateo gave the verbal order for the Milk of Magnesia, that he questioned Dr. Mateo about the unusually high dose and that Dr. Mateo confirmed the dose. Appellant argues that he did not normally act on a verbal order, but that he did so on this occasion because he believed that it was an emergent situation. Appellant argues that Respondent has failed to implement a program of progressive discipline and that a permanent demotion for a long-term employee is too severe.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

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4.7 Respondent has proven that Appellant neglected his duty and willfully violated hospital policy when he acted on a verbal order to dispense medication to a patient without confirming that the verbal

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1	order had been written in the patient's chart. Respondent has clearly shown that verbal orders for
2	dispensing medication were against policy and acceptable only under very limited circumstances.
3	Respondent has also proven that Appellant neglected his duty and willfully violated hospital policy
4	when he failed to chart the medication on the patient's progress notes and medication administration
5	record. Appellant's misconduct interfered with the hospital's ability to ensure that patients receive
6	quality patient care and rises to the level of gross misconduct.
7	
8	4.8 As a licensed practical nurse, Appellant was responsible for protecting patients from unsafe
9	practices and neglect. However, Appellant chose to disregard the policies of the hospital and he must be
10	held accountable for the actions he took on June 14, 1998. In this case, Dr. Dennis demoted Appellant
11	to a position where Appellant would no longer administer medications. The seriousness and
12	circumstances of this incident warrant a severe disciplinary sanction. Therefore, we conclude that the
13	sanction of demotion is appropriate and the appeal should be denied.
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15	V. ORDER
16	NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Cameron Wheelock is denied.
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18	DATED this, 1999.
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20	WASHINGTON STATE PERSONNEL APPEALS BOARD
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22	Walter T. Hubbard, Chair
23	Water T. Hacourd, Chair
24	Countd I. Mangan Was Chain
25	Gerald L. Morgen, Vice Chair
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